Boyd (Geo. M.)

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BY

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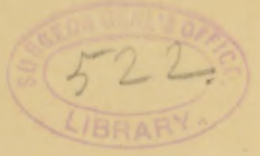

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A CASE OF PUERPERAL PELVIC ABSCESS, WITH SOME REMARKS ON SEPTIC INFECTION.*

By George M. Boyd, M. D.,
Physician to the Philadelphia Lying-in Charity.

The case which I have to report this evening has prompted me to make a few remarks in regard to septic infection—not in reference to how the poisons or germs bring about their chain of symptoms characteristic of sepsis in its various forms, but as to the probable most frequent seats of inoculation.

It will be convenient for this purpose to divide the parturient canal into *three* portions:

1. The *uterine* portion, most remote from external contamination.
2. The *cervical* portion, more liable to infection.
3. The *vaginal* portion, directly exposed to all the poisons or germs.

Septic infection must develop in one of two ways—either the poison is introduced from without, or our patient is self-inoculated.

Given the two sources of infection, the uterine portion of the canal, even with its many venous sinuses and highly constructed lymphatic system, would seem least liable to primary inoculation. The non-puerperal uterus within the external os seldom contains the several bacteria which are found in the cervical or vaginal portion. Then, too, this, the uterine portion, is farthest from external contamination. If it *is* the usual seat of infection, is not the poison frequently carried there from the cervical or vaginal portion?

The cervical portion of the canal is not only nearer the introitus vaginæ, but encounters an additional danger because of traumatic injury.

Lacerations of this portion give us numerous foci for inoculation by putrefactive products or poisonous germs from without.

The vaginal portion is constantly in danger of infection, possessing many wounds all along its tract, from perinæum to external os.

* Read before the Philadelphia Obstetrical Society, November 1, 1894.

It would seem, then, that this portion was the most frequent seat of direct inoculation. The cervical less frequent. The uterine least frequent. In observing the puerperium in about twelve hundred cases treated at the Philadelphia Lying-in Charity in the past four years, I have been impressed with the freedom of symptoms which pointed to uterine infection. The tender uterus has been almost absent.

The non-infectious fevers being excluded, an occasional elevation of temperature must be explained in cervical or vaginal wound infection. I do not mean to imply that we do not have primary uterine infection, and that even in some cases it would seem that the poison had passed through the uterus and lodged in the Fallopian tube, or even, further than this, carried directly into the peritoneal cavity without injury to the tube or uterus.

It does seem to me, however, where the usual precautions are taken (in these days of clean obstetrics), that when we have some elevation of temperature and other evidence of mild infection, trauma produced during labor has very much influenced the seat of inoculation.

In clean work, the mild forms of infection are not difficult to combat, and for the most part, I believe, are due to auto-inoculation.

The following history of a case of puerperal pelvic abscess is of some interest, not only as to the probable seat of infection, but also as to the wisest method of treating these cases :

Mrs. A., an Italian, aged twenty-six years, was admitted to the Charity, March 20, 1894, at the request of my friend Dr. H. M. Fisher. Six weeks before her admission she had been delivered by a midwife. The labor itself was not difficult, but soon she developed fever ; and when Dr. Fisher was called at about the fourth week after her delivery, she was very ill, unable to leave her bed, temperature ranging from 100° to 102° F. Her tongue was coated, no appetite, and she had the relaxed moist skin of septic infection. Upon examination, the labia of the right side was found somewhat tumefied. A mass, filling the right side of the pelvis and pushing a well-involuted uterus to the left, was felt.

Externally in the right groin could be felt a tumor resembling very much an ovarian enlargement. When I saw her about six weeks after her delivery, with the exception of the swelling of the right labia, which was absent, she was much worse. Pulse feeble, skin bathed in a profuse sweat, and she had lost much in weight.

Was it a simple pelvic abscess? Was it a pelvic abscess with

puerperal tubo-ovarian disease? Or was it a localized puerperal pelvic peritonitis with slight tubo-ovarian trouble?

Dr. Fisher had already mentioned the hospital. I was very glad he had, for among the Italians there seems to exist a great fear of institutions. After some persuasion she consented to be taken to the hospital, as she stated, "to die."

On March 22, 1894—two days after admission—with the counsel and assistance of my associates, Drs. Hopkinson and Wilson, I operated. It was deemed wisest, although there was no fluctuation or pointing, to cut down, above, and parallel to Poupart's ligament, that an extraperitoneal pus accumulation might be relieved. With a rather obscure diagnosis this course seemed wiser than immediately opening the general peritoneal cavity for tubo-ovarian trouble.

An incision of about two inches was made; after opening the aponeurotic sheath of abdominal muscles and severing the latter, slight fluctuation was felt.

An abscess was incised with the escape of about two ounces of pus. The abscess cavity was washed out and an iodoform-gauze drain introduced. There immediately followed an amelioration of symptoms, and in three weeks she left the hospital recovered. Three months after the operation I made an examination, and could find no evidence of the original trouble. From a thin and anæmic condition she had grown stout.

In conclusion, I would state that this particular case seemed to me to be one of infection of the vaginal portion of the parturient canal, and it is quite possible that throughout our patient's long illness the uterus never became infected.